Cheshire & Merseyside
Cancer Alliance

Cheshire and Merseyside Optimal Colorectal Pathway

This document was produced by the Cheshire and Merseyside Colorectal Project Delivery Group
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Overview of document changes:

The advent of local implementation meetings have highlighted the need to incorporate colonoscopy for patients who have received a CT Colonography. This takes place where clinically appropriate and further stratification of the colorectal pathway has taken place to incorporate this and facilitate efficient tracking of the patient. All relevant key principles have also been amended.

Additionally, a further in depth review has taken place concerning the pathway and other amendments have taken place specifically in relation to language and the presentation of the key principles

Prepared by:

The Cheshire & Merseyside Colorectal Delivery Group, which is chaired by Mr Liviu Titu and includes representation from the full range of professions involved in delivering colorectal cancer services with commissioning representation.

Audience:

This document is intended for colorectal cancer service providers, commissioners and other key stakeholders appropriate for the delivery of the optimal colorectal pathway. It will also be of interest to those involved in developing cancer policy.

Groups consulted:

There has been wide consultation across Cheshire & Merseyside. The groups consulted are listed below and include those who are involved in delivering colorectal cancer services across Cheshire & Merseyside as well as commissioning it:

- Colorectal Clinical Network Group
- Cancer Managers Action Group
- Cancer Lead Nurse Group
- Imaging Programme Board
- Cheshire and Merseyside
- Endoscopy Delivery Group
- Cancer commissioners

Purpose of this document

This document provides an overview of the optimal, timed colorectal cancer pathway for patients referred on an Urgent Two Week Wait Referral for Suspected Colorectal Cancer. It aims to provide relevant information that can be used by all professions and as a supportive document for tracking of suspected and diagnosed cancer patients until definitive first treatment is received.

The document has been informed by the Colorectal Delivery Group, which has representation from 9 trusts and has representation form the following professions:

- Surgery
- Oncology
- Radiology
- Endoscopy
- Pathology
- Cancer Commissioning
- Primary Care
- Cancer Management

Purpose of this document (Continued)

The pathway has further been designed to take in to account the following:

- Variation in timings according to type of first contact
- National Cancer Waiting Times Standards
- Cheshire and Merseyside Breach Reallocation Policy
- Ambition to achieve 50% of patients excluded from/diagnosed with cancer by 14 days and 95% by 28 days

Whilst implementing this optimal pathway will be a challenge and there are important relationships with diagnostic capacity and demand that need to also be addressed, it is also recognised that this pathway represents an opportunity to further develop colorectal cancer services.

It is further recognised that there are key interfaces with diagnostics to support the implementation of this pathway and local implementation teams are important in working towards this. Currently, for example, there are particular challenges in some areas with regards to endoscopy, radiology and pathology. It is recognised that some of these challenges may take some time to address. Working towards implementation of this pathway can be done using a segmented approach.

The times in the pathway are recommended and aim to balance the requirements of each area of the pathway from diagnostics through to first definitive treatment. The length of the pathway is ultimately dependent on the type of contact the patient first receives i.e. clinical assessment or first diagnostic test. Additionally, the timings of the pathway are also affected by the type of definitive diagnostic test and treatment type.

Key principles addressing the following are also considered in this document:

- Principles of referral e.g. use of standardised TWW referral forms and patient communication
- Principles of "Straight to Right Test" e.g. ordering staging investigations and informing patients of confirmation of or exclusion from cancer
- MDT and pathway management e.g. PTL meetings, inter-trust communications
- Surgical treatment
- Oncology treatment
- Patient support e.g. completion of Holistic Needs Assessments and Making Every Contact Count (MECC)

Although there may be a need for further diagnostic tests for individuals, this pathway only deals with these in the context of colonoscopy/flexible sigmoidoscopy after CT Colonography if clinically appropriate. This is due to the clinical need to obtain histological proof of diagnosis to inform a treatment plan as per local clinical expertise and NICE Clinical Guidance CG131; Colorectal cancer: diagnosis and management

To view the relevant pathway, please click the appropriate link below:

Click here for patient NOT ELIGIBLE for "Straight to Right Test"

Click here for patient ELIGIBLE for "Straight to Right Test"

Key pathway timings

The following table highlights key timings only. More detailed key principles can be found at the end of this document

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PLEASE NOTE: For specific days to aid with patient tracking, please refer to the pathways within this document

Pathway element	Timings and pathway principles
Referral receipt	**This qualifies as day 0 of the pathway** Clinical review of the referral form will take place on Day 0/1 of the pathway
Clinical Assessment	**This will take place by day 7 of the pathway** where clinically appropriate
Endoscopy testing as first diagnostic test	**This will occur within 7 days** of either a clinical assessment or a clinical review of the referral from for patients going "Straight to Right Test".
CT Colonography	• **This will be performed within 7 days** of either a clinical assessment or a clinical review of the referral from for patients going "Straight to Right Test". • A CT Chest will be performed on the same day where there are suspicious findings • A full report will be available within 3 days from when the scan is performed and the referring clinician informed of suspicious/normal result the same day. Staging investigations should be ordered on the same day
Colonoscopy/flexible sigmoidoscopy as a further diagnostic test after CT Colonography	Where it is clinically appropriate for a patient to receive a colonoscopy/flexible sigmoidoscopy as a further diagnostic test, then **this should take place within 4 days**.
Histopathology	**Results of histopathology will be available within 5-7 days.**
Staging investigations	**Turnaround for imaging should be 7 days from request to report** with the exception of CT Colonography, which has a 10 day turnaround
Local MDT (Care Plan agreed)	**This will take place 2-3 days after staging is available**
Treatment discussion OPA	**This will take place 1-2 days after the Local Trust MDT where a Care Plan Intent is confirmed**
Pre-op assessment	**To take place within 7 days of outpatient appointment where a treatment plan has been agreed with the patient**
Surgery	**Each pathway highlights the maximum day by which surgery should have taken place.** It is accepted that surgery may take place sooner than this is clinically appropriate
Oncology OPA	**This will occur within 7 days of outpatient appointment where a treatment plan has been agreed with the patient**
Chemotherapy pre-assessment	**To take place within 4 days of being seen in Oncology OPA**. NB it is acknowledge that pre-assessment does not take place in Mid or East Cheshire due to pathway variations with Greater Manchester.
Chemotherapy regime begins	**To begin within 3 days of pre-assessment appointment.**
Radiotherapy planning appointment	**To take place within 4 days of being seen in Oncology OPA**
Radiotherapy – delivery of 1st fraction	**To begin within 10 days of planning appointment.**

NOT eligible for "Straight to Right Test"

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Throughout pathway: consider entry in to a research trial; use opportunities for Making Every Contact Count (MECC)

Day 0
Day 1
Day 7
Day 14
Day 17
Day 21
Day 28
Day 31
Day 33
Day 35
Day 37
Day 38
Day 40
Day 44
Day 47
Day 49
Day 52
Day 54
Day 57
Day 59
Day 62

PLEASE NOTE: The key principles contain further detail which needs to be considered and applied. Also consider the following:
Key principle 1 – Referrals information received from primary care and other routes to diagnosis
Key principle 6 – Patient Support e.g. HNAs, CNS support

Day 0
Two Week Wait GP referral received by trust CWT Date First Seen clock starts (Key principles 2.1, 2.2, 2.3)

Day0/1
Clinical review of referral form;
(Key principle 2.1, 2.2, 2.3)

Day 7
Clinical assessment; CWT Date First Seen clock stops (Key principle 2.4)

Day 14
CT Colonography as first diagnostic test
(Key principle 2.4; 2.6)

Day 17
Full imaging report available for CT colonography (Key principle 2.4; 2.6)

Day 21
Colonoscopy/flexible sigmoidoscopy performed if clinically appropriate
(Key principle 2.5; 2.6; 2.7)

Day 28
Histopathology results reported; staging investigations ordered and for indeterminate lesions; **Patient informed**
(Key principle 2.7; 2.8; 2.9)

Day 35
Staging investigations completed (Key principle 2.9)

Day 37
Local MDT; treatment discussed (key principle 3.1)

Day 38
OPA for treatment decision/discussion **(CWT Decision to Treat date)**; **Onward referrals**; **Active monitoring/palliative care** (where there is no active treatment) commences **(Treatment start date)**
(Key principles 3.2 to 3.9)

Day 45
Surgical pre-op assessment/Oncology OPA
(Decision to treat date for Oncology)
(Key principle 4.1, 5.1)

Day 49
Chemo pre-assessment/Rx planning appt
(Key principle 5.2,5.4)

Day 52
Chemotherapy regime begins (unless significant decision time required)
(Key principle 5.3)
(Treatment start date)

Day 59
Delivery of first radiotherapy fraction
(Key principle 5.5)
(Treatment start date)

Day 62
Surgery performed
(Key principle 4.2)
(Treatment start date)

Day 14: 50% patients diagnosed/excluded

Day 28: 95% patients diagnosed/excluded

Day 38: Referral to treating trust deadline
24 days to complete treatment

Day 14
Endoscopy as first diagnostic test
(Key principle 2.5; 2.6)

Day 21
Histopathology results reported; staging investigations ordered and for indeterminate lesions; **Patient informed**
(Key principle 2.7; 2.8; 2.9)

Day 28
Staging investigations completed (Key principle 2.9)

Day 31
Local MDT; treatment discussed (key principle 3.1)

Day 33
OPA for treatment decision/discussion **(CWT Decision to Treat date)**; **Onward referrals; Active monitoring/palliative care** (where there is no active treatment) commences **(Treatment start date)**
(Key principles 3.2 to 3.9)

Day 40
Surgical pre-op assessment/Oncology OPA
(Decision to treat date for Oncology)
(Key principle 4.1, 5.1)

Day 44
Chemo pre-assessment/Rx planning appt
(Key principle 5.2,5.4)

Day 47
Chemotherapy regime begins
(unless significant decision time required)
(Key principle 5.3)
(Treatment start date)

Day 54
Delivery of first radiotherapy fraction
(Key principle 5.5)
(Treatment start date)

Day 57
Surgery performed
(Key principle 4.2)
(Treatment start date)

Day 62: receipt of first treatment

Eligible for "Straight to Right Test"

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Throughout pathway: consider entry in to a research trial; use opportunities for Making Every Contact Count (MECC)

PLEASE NOTE: The key principles contain further detail which needs to be considered and applied. Also consider the following:
Key principle 1 – Referrals information received from primary care and other routes to diagnosis
Key principle 6 – Patient Support e.g. HNAs, CNS support

Day 0
Two Week Wait GP referral received by trust
CWT Date First Seen clock starts (Key principle 2.1, 2.2, 2.3)

Day 0/1
Clinical review of referral form
(Key principle 2.1, 2.2, 2.3)

Day 7
CT Colonography as first diagnostic test
(Key principle 2.5; 2.6)
CWT Date First Seen clock stops

Day 7
Endoscopy as first diagnostic test
(Key principle 2.5; 2.7)
CWT Date First Seen clock stops

Day 10
Full imaging report available for CT Colonography (Key principle 2.5; 2.6)

Day 14: 50% patients diagnosed/excluded

Day 14
Colonoscopy/flexible sigmoidoscopy performed if clinically appropriate
(Key principle 2.5; 2.6; 2.7)

Day 14
Histopathology results reported; staging investigations ordered and for indeterminate lesions; **Patient informed**
(Key principle 2.7; 2.8; 2.9)

Day 21
Histopathology results reported; staging investigations ordered and for indeterminate lesions; **Patient informed**
(Key principle 2.7; 2.8; 2.9)

Day 21
Staging investigations completed (Key principle 2.9)

Day 24
Local MDT; treatment discussed (key principle 3.1)

Day 26
OPA for treatment decision/discussion (CWT Decision to Treat date); **Onward referrals; Active monitoring/palliative care** (where there is no active treatment) commences (Treatment start date) (Key principles 3.2 to 3.9)

Day 27
Staging investigations completed (Key principle 2.9)

Day 28: 95% patients diagnosed/excluded

Day 29
Local MDT; treatment discussed (key principle 3.1)

Day 31
OPA for treatment decision/discussion (CWT Decision to Treat date) ; **Onward referrals**; **Active monitoring/palliative care** (where there is no active treatment) commences (Treatment start date)
(Key principles 3.2 to 3.9)

Day 33
Surgical pre-op assessment/Oncology OPA
(Decision to treat date for Oncology)
(Key principle 4.1, 5.1)

Day 37
Chemo pre-assessment/Rx planning appt
(Key principle 5.2,5.4)

Day 38
Surgical pre-op assessment/Oncology OPA
(Decision to treat date for Oncology)
(Key principle 4.1, 5.1)

Day 38: Referral to treating trust deadline
24 days to complete treatment

Day 40
Chemotherapy regime begins
(unless significant decision time required)
(Key principle 5.3)
(Treatment start date)

Day 42
Chemo pre-assessment/Rx planning appt
(Key principle 5.2,5.4)

Day 45
Chemotherapy regime begins (unless significant decision time required)
(Key principle 5.3)
(Treatment start date)

Day 47
Delivery of first radiotherapy fraction
(Key principle 5.5)
(Treatment start date)

Day 50
Surgery performed
(Key principle 4.2)
(Treatment start date)

Day 52
Delivery of first radiotherapy fraction
(Key principle 5.5)
(Treatment start date)

Day 56
Surgery performed
(Key principle 4.2)
(Treatment start date)

Day 62: receipt of first treatment

Detailed key pathway principles

1.0 Referrals

Key Principles		How we do it
1.1	**Primary Care investigation/referral**	Use of standardised referral form with core information for appropriate referral, including NICE referral guidance (NG12). Abdominal and Digital Rectal Examination by GP to be included in form and completed prior to referral
1.2	**Patient communication**	GP to communicate reason for referral to the patient and the need for them to attend ALL appointments GP to inform patient of relevant trust communication processes for diagnostic tests or clinical assessment
1.3	**Suspected colorectal cancer emergency presentation**	Patients presenting with symptoms suspicious of colorectal cancer should be referred to the colorectal team ASAP and seen within 7 days. Patients could present via an emergency route via A&E, emergency GP referral, emergency consultant outpatient referral, emergency transfer, emergency admission or attendance
1.5	**Consultant upgrades**	Patients who have an incidental finding in a general clinic and are non-emergencies should be upgraded: • On receipt or triage of referral where this meets the NICE referral guidelines criteria for suspicion of cancer. • During or following initial visit, cancer is suspected. • During or following diagnostic procedures where imaging or histology/cytology indicate or confirm the presence of cancer. • On or before the multi-disciplinary team (MDT) meeting date that plans the treatment.
1.6	**Referrals from other suspected cancer pathways**	A rapid access route will be available in to the Local Colorectal MDT as per local arrangements to avoid unnecessary delays

2.0 Diagnosis and staging

Key Principles		How we do it
2.1	**Clinical vetting of referral forms**	The trust commits to a clinical review of the referral form within 0/1 days of referral receipt by trust. This clinical review will facilitate referral of patients to either an outpatient appointment or the most appropriate test.
2.2	**Patient communication**	The trust commits to appropriate patient communication to ensure appointment attendance, successful bowel prep etc…
2.3	**Investigation criteria for straight to diagnostic test**	Cheshire & Merseyside agreed referral/exclusion criteria for appropriate test/outpatient clinic where clinically appropriate and concordance is reached
2.4	**Clinical assessment**	This will take place where the patient is not appropriate for STRT and will be done either via an outpatient appointment or CNS telephone review within 7 days of referral receipt by the trusts. Local agreements may mean that the latter can be used to 'stop the clock' for CWT Date First Seen if there is a clear protocol and it is properly monitored/audited/evaluated . It is acknowledge that in some cases, for example, rectal cancer, it may be possible to order staging investigations on the same day as the outpatient appointment if that has taken place
2.5	**First diagnostic test**	Trusts committed to internal target of 7 days to test performance from either the clinical review for eligible patients or from the clinical assessment of the patient if that is the clinically appropriate pathway. Where clinically appropriate, all further tests should be ordered on the same day following a diagnostic test The following specific detail is relevant for each investigation: • CT colonography: o There will be a 10 turnaround for this test from request to full report o There will be an initial review of the image at the same time the examination is performed by an appropriately trained radiographer/radiologist to determine the need for staging and/or acute treatment for a potential obstruction, for example. This can be performed while the patient is in the department. A CT Chest will then performed at this point where it is clinically appropriate o A full report will be available within 3 days from when the scan is performed and the referring clinician informed or suspicious/normal result. Staging investigations should be ordered on the same day o If it is clinically appropriate to offer the patient a colonoscopy, this should be done on the same day as the receipt of the full report and take place within 4 days • Endoscopic investigations: o Patients will be informed of suspicious/normal result on the same day. Staging investigations should be ordered on the same day if strong suspicion of malignancy on scope. Indeterminate lesions should await biopsy results before ordering staging investigations o Please note: It is acknowledged that a small proportion of people may experience an incomplete colonoscopy e.g. for poor bowel prep or intolerance. Although this does not feature explicitly within this pathway, it is acknowledged that these patients will require a CT Colonography and that it may be clinically appropriate to wait before this is performed. Alternatively, a CTVC needs requesting on the same day if clinically appropriate.

2.0 Diagnosis and staging (continued)

Key Principles		How we do it
2.6	**Colonoscopy/flexible sigmoidoscopy performed as a second diagnostic test**	It is recognised that this may be used as a follow-up test for patients receiving a CT Colonography. If it is clinically appropriate to offer the patient these tests then the following should be the case: • Colonoscopy/flexible sigmoidoscopy ordered on the day that the full report is produced • Tests to take place within 4 days. • Where clinically appropriate, all further tests should be ordered on the same day following a diagnostic test It is acknowledge that for some of these patients, some delays may be mitigated for where a CT Chest has been done at the time of suspicion when the CT Colonography is performed. Please note: It is acknowledged that a small proportion of people may experience an incomplete colonoscopy e.g. for poor bowel prep or intolerance. Although this does not feature explicitly within this pathway, it is acknowledged that these patients will require a CT Colonography and that it may be clinically appropriate to wait before this is performed.
2.7	**Confirmation/exclusion of cancer**	Trusts committed to informing 50% of patients of confirmed diagnosis/non-diagnosis within 14 days of referral receipt and 95% within 28 days of referral receipt. This will be communicated to the patient by virtual/telephone/letter follow-up where appropriate. Patients with no cancer will be referred in to other specialties where clinically appropriate or required. Please note: The specifics behind what is a definitive diagnosis and informing the patient of this may change depending on NHS England definitions and communication requirements. Key principle 2.5 contains further information on informing patients of investigations results. Virtual follow-up has been implemented i.e. for when patients are excluded from cancer/have normal results
2.8	**Histopathology**	• Biopsy histopathology results available within 5-7 days. This will include immunohistochemical testing where required (NB it is acknowledged that this may occur at surgical resection) • Patients who receive a –ve biopsy result but where cancer is still a possibility may potentially occur in patients with high grade dysplasia, but where there is still a clinical suspicion of cancer. Use CNS to inform patient and coordinate care if repeat Bx required
2.9	**Staging investigations**	These will be ordered on the same day as receipt of endoscopic/imaging results from initial investigation if strong suspicion of malignancy on scope. Indeterminate lesions should await biopsy results before ordering staging investigations. The trust will work towards a 7 day turnaround from request to full report

3.0 MDT and pathway management

Key Principles		How we do it
3.1	**Local MDT**	The treatment plan will be discussed at this point with staging, pathology and other requirements presented. The Care Plan Intent will be agreed
3.2	**OPA/Clinical discussion of management plan**	This will take place within 2 days of the local MDT. The decision to treat will be confirmed in this forum. Please note that this may mean that there will not be 31 days from this point for treatment to be carried out if the DDT is after day 31
3.3	**Clinical Trials/Research**	The offer of research trials should be made at the treatment OPA where appropriate
3.4	**Referral to specialist MDTs**	Referral to Papillon MDT/Anal MDT/Specialist Early Rectal Cancer MDT/Advanced Colorectal MDT should occur following a discussion with the patient during an OPA after the local MDT. Referrals should be made the same day
3.5	**Referral to oncology**	Referral will take place on the same day as the treatment has been discussed with the patient in an OPA
3.6	**Palliative care/Active Surveillance**	Where there is no active palliative treatment or active surveillance/monitoring is required, this will begin on the same day as key principle 3.2 above
3.7	**Weekly PTL / tracking meeting**	Weekly PTL Meeting with Clinical and Managerial input alongside the Cancer Management Team and MDT coordinator/tracker. Patients remain on PTL and are tracked until treatment is completed
3.8	**Communication between trusts**	Completion of Advanced Colorectal, Anal and Specialist Early Rectal Cancer MDT discussion proforma with all MDS requirements and investigation reports.
3.9	**Handover to treating Trust by day 38**	CNS communication/handover between Trusts. This should occur at the point where there is transfer of care between organisations All patients to be formally referred to the treating Trust (where there are 2 or 3 Trust pathways) by day 38. CARP form completed and sent to treating trust along with any reasons for delay.

4.0 Surgical treatment

Key Principles		How we do it
4.1	Pre-op assessment	To take place within 7 days of outpatient appointment where the treatment has been discussed and agreed with the patient. Please note that this may mean that there will not be 31 days from this point for treatment to be carried out if the Decision to Treat is on day 33, for example
4.2	Surgery	The maximum day for surgery is presented within each pathway. It is acknowledged that treatment may take place sooner if this is clinically appropriate however, time may be needed for patient pre-hab, anaemia, pre-op optimisation. Increased time for pre- hab may have a positive impact on patient outcomes

5.0 Oncology

Key Principles		How we do it
5.1	**Oncology OPA**	To take place within 7 days of outpatient appointment where the treatment has been discussed and agreed with the patient. Please note that this may mean that there will not be 31 days from this point for treatment to be carried out if the Decision to Treat is on day 33, for example
5.2	**Chemotherapy pre-assessment**	Within 4 days of being seen in Oncology OPA. (NB it is acknowledged that pre-assessment does not take place in Mid or East Cheshire due to pathway variations with Greater Manchester.
5.3	**Chemotherapy regime begins**	Chemotherapy treatment will begin within 3 days of pre-assessment appointment. It is acknowledged that treatment may take place sooner if this is appropriate or later if significant thinking time is required . It is further acknowledged that some patients may require significant decision-making time which may require an additional outpatient appointment or small delay in treatment beginning
5.4	**Radiotherapy planning appointment**	This will take place within 4 days of being seen in Oncology OPA
5.5	**Radiotherapy – delivery of 1st fraction**	This will begin within 10 days of planning appointment. It is acknowledged that treatment may take place sooner if this is clinically appropriate.

6.0 Patient support

Key Principles		How we do it
6.1	**Early access to CNS / support team**	CNS contact will be made when the patient has had a confirmed diagnosis of cancer. Trust committed to CNS being present at diagnosis OPA.
	Making Every Contact Counts (MECC)	All staff to employ the “Make Every Contact Count” (MECC) principles.
	Health & Well-Being Events and patient information	Patients referred to the local Macmillan information and support service and Health & Wellbeing events where/when available.
6.2	**Holistic Needs Assessment**	Trust will complete this at diagnosis for all appropriate patients and provide information prescription applicable for patient needs CNS to complete HNA at diagnosis
6.3	**End of Treatment Summary**	These should be done at the end of each acute treatment phase and sent to both the patient and the GP. They should be completed by secondary care clinicians.
6.5	**Risk stratified follow-up**	Trust will take part in pilots and roll-out where applicable